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The silent struggle

Understanding the experience of being in treatment for anorexia nervosa

Author: Mathilda Juhlin & Nikita Martinsson Wahab

Supervisor: Carrie Tran District nurse, Lecturer, Med.Dr

Examiner: Tommy Carlsson Associate Professor, Med. Dr

Swedish Red Cross University
Visiting address: Hälsovägen 11C, 141 57 Huddinge | Postal address: Röda Korsets Högskola, P.O. Box 1059, 141 21 Huddinge, Sweden | Telephone: +46 (0)8 – 587 516 00 | E-mail: info@rkh.se | www.rkh.se

ABSTRACT IN SWEDISH

Bakgrund: Anorexia nervosa (AN) är en komplex och allvarlig psykologisk störning med den högsta dödligheten av alla psykiska sjukdomar. Behandlingsmetoder fokuserar ofta på viktuppgång och fysisk återhämtning, vilket riskerar att förbise de underliggande emotionella och psykologiska aspekterna. Detta snäva fokus leder till att patienter upplever en förlust av autonomi och identitet samt misstro gentemot vårdgivare.
Syfte: Syftet med denna studie var att utvärdera och syntetisera kvalitativa studier som utforskar kvinnors levda erfarenheter av att vara i behandling för Anorexia Nervosa
Metod: Studien genomfördes som en kvalitativ litteraturstudie. Tolv vetenskapliga originalartiklar, systematiskt sökta i databaserna CINAHL och PubMed, granskades och endast artiklar av måttlig eller hög kvalitet inkluderades. Data analyserades induktivt med tematisk analys enligt Braun och Clarkes ramverk.
Resultat: Begränsat fokus på vikt och BMI förstärker anorektiska mekanismer och att en stark vårdrelation är viktigare för engagemang än själva behandlingsmetoden. Bristande kontinuitet vid övergångar i vården leder till stor risk för återfall.
Slutsatser: Behandling av AN kompromissas av ett snävt fokus på fysiska mått. En personcentrerad vårdmodell, grundad i förtroende och empati, är avgörande för patienternas långsiktiga återhämtning. Vårdpersonal måste säkerställa kontinuerligt stöd under övergången till öppenvård för att minska risken för cykliska återinläggningar. Denna studie understryker behovet av fortsatt forskning om mer personcentrerade vårdmodeller.
Nyckelord: Anorexia Nervosa, Kontinuitet av vård, Levd erfarenhet, Personcentrerad vård, Terapeutiska relationer.

ABSTRACT

Background: Anorexia Nervosa is a complex, severe psychological disorder associated with the highest mortality rate among psychiatric illnesses. Treatment often overly emphasizes weight gain and physical recovery, neglecting underlying psychological and emotional aspects. This narrow focus leads patients to feel a loss of autonomy, identity, and deep mistrust towards caregivers.

Aim: The aim of this study was to evaluate and synthesize qualitative studies exploring women's lived experiences when in treatment for Anorexia Nervosa

Method: The study was conducted as a qualitative literature review. Twelve scientific original articles, systematically searched in the CINAHL and PubMed databases, were critically appraised, and only articles of moderate or high quality were included. Data were analyzed inductively using thematic analysis based on Braun and Clarke's framework.

Results: The reliance on weight and BMI reinforces anorectic mechanisms. A strong therapeutic relationship, based on trust, is more critical for patient engagement than the specific treatment approach. Lack of continuity during transitions significantly increases the risk of relapse.

Conclusions: Treatment is fundamentally compromised by an overly narrow focus on physical metrics. A person-centered care model, founded on trust and empathy, is crucial for patients' long-term recovery. Caregivers must ensure continuous support during the transition to outpatient care to mitigate cyclical readmissions. Further research into person-centered models is necessary.

Keywords: Anorexia Nervosa, Continuity of care, Lived experience, Person-centered care, Therapeutic relationships.

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INTRODUCTION

As we are both nursing students and young women, we have experienced the physicality and ideals that characterize today's society. These norms may affect self-esteem and mental well-being, and we share an understanding of the challenges many women face. Based on our own experiences, we have developed a strong interest in exploring how women experience their treatment for anorexia nervosa. Furthermore, one of the authors has worked in an eating disorder clinic and has witnessed these women's challenges up close on a daily basis. As students in the nursing program, we have gained a greater understanding of how important nursing is for patients and can imagine what a challenge it must be as a patient to be treated for a mental illness, which in many cases becomes so serious that it becomes physical where the body is damaged. It is important as future nurses to understand the disorder and to be able to identify the specific needs of the individual person. And to gain more insight in order to offer better care.

BACKGROUND

Anorexia nervosa is a life-threatening psychological disorder

According to the National association of anorexia nervosa and associated disorders (2024) Anorexia nervosa (AN) is a serious psychological disorder that can lead to long-term disruptions in individuals lives, with medical complications often resulting in hospitalization, extended treatment, and causing significant effects on the individuals daily functioning. AN has the highest case mortality rate while also being the second-highest crude mortality rate of any mental illness. Patients with AN also have increased risk of suicide and is eighteen times higher than those without an eating disorder (National association of anorexia nervosa and associated disorders, 2024).

Anorexia nervosa and diagnostic criteria

Quadflieg et al. (2023) writes that AN is characterized by self-induced weight loss and that it most frequently begins in childhood and adolescence. Diagnostic criteria include a low body mass index (BMI) of less than 18.5 kg/m2, a fear of gaining weight, and preoccupation with body, weight and shape. Generally, there are two types of AN described. One where Weight loss is primarily achieved through restricting food intake, fasting, or excessive exercise. The other one is Binge-eating/purging type where individuals attempt to lose weight by limiting food and engaging in behaviors that expedite weight loss, such as self-induced vomiting, using laxatives, or engaging in excessive physical activity (Quadflieg et al., 2023).

Prolonged AN means that the individual remains severely ill despite several treatment attempts; some therefore have a long-standing state of starvation and suffer from serious medical and psychiatric complications. Individuals can also receive the diagnosis without being underweight when the other criteria are met, but the BMI is within the normal range. This is called Atypical Anorexia, and it is common for individuals to still lose a significant amount of weight (Socialstyrelsen, 2024, p. 14). Kunskapscentrum för ätstörningar (nd) adds that individuals with AN often experience deep dissatisfaction with themselves and their bodies. To these individuals, controlling their weight may feel necessary, and the idea of gaining weight can be terrifying. This fear continues even if they are dangerously thin, and they may still see themselves as overweight. Family and friends around them may express serious concern over their weight loss, but the person with AN may not fully realize the physical and mental toll of starvation. For someone with this illness, thoughts about food, eating, and body image can dominate their minds. Concentration and sleep may become difficult, and many individuals with the disorder hold themselves to extremely high standards, striving for perfection. These ideals are often not only in weight loss but also in other areas of their lives. Internally, they may struggle with intense feelings of isolation, shame, and despair (Kunskapscentrum för ätstörningar, nd).

Incidence and prevalence

According to Van Eeden et al. (2021) the incidence rates of AN vary depending on study design, population characteristics, and diagnostic criteria. The population-based studies have reported the following incidence rates: Sweden: 120 per 100,000 person-years among females aged 20–32 years; Spain: 200 per 100,000 person-years among females aged 12–22 years; Finland: 270 per 100,000 person-years among female twins aged 15–19 years. Incidence estimates derived from outpatient healthcare services indicate a rate of 8.8 per 100,000 person-years (95% confidence interval (CI): 7.8–9.8), which exceeds the incidence rate observed in hospital admission-based studies (5.0 per 100,000 person-years; 95% CI: 4.9–5.1). Studies consistently show that Anorexia Nervosa disproportionately affects women, with the highest incidence rates occurring among females aged 10–29 years. Stratified analyses suggest that the highest incidence rates occur among females aged 10–29 years, with outpatient healthcare data showing an incidence of 63. 7 per 100,000 person-years

(95% CI: 61.2–66.1), while hospital admission rates in the same age group were substantially lower (8.1 per 100,000 person-years; 95% CI: 7.6–8.5). Longitudinal analyses of healthcare register-based studies indicate a marked increase in the incidence of AN, particularly in outpatient settings. However, this trend may not necessarily reflect a genuine rise in disease prevalence but could instead be attributed to enhanced public awareness, improved diagnostic accuracy, and increased access to treatment (Van Eeden et al., 2021). Studies consistently show that Anorexia Nervosa disproportionately affects women, with the highest incidence rates occurring among females aged 10–29 years and certain populations (Sweden and Finland, between 120 and 270 per 100,000 person-years). This demographic focus is further justified by the gender-specific physiological impacts of the disorder, such as weight loss-related amenorrhea and the significant risk of impaired bone density in women of reproductive age. Because this group represents the vast majority of clinical cases, exploring the lived experiences of women is essential to identify the specific needs of the individual and to develop nursing strategies that effectively support their long-term recovery and identity development.

Long term effects

When the body is in starvation, it can cause a lot of severe symptoms that can become life-threatening. The impact of starvation on the body depends on its duration and the rate of weight loss (Kunskapscentrum för ätstörningar, nd). Rapid weight loss can be more detrimental than a gradual decline, as the body struggles to adapt. Starvation disrupts the body's natural signaling systems, affecting a persons ability to recognize hunger and satiety cues. It also results in a deficiency of essential nutrients. Prolonged starvation during youth can affect growth and lead to conditions such as osteoporosis. When the body is deprived of fuel, it conserves energy. One symptom is constipation and abdominal discomfort, which can for these individuals be misinterpreted as feeling "fat" or uncomfortable in their body. This occurs because the intestines have little to process, and the body reduces energy expenditure, slowing down bowel function. Many experience abdominal pain, constipation, or gas, as well as fatigue. A body in starvation mode attempts to conserve energy to survive, which can affect various functions. The pulse may decrease, body temperature may drop, and the person may experience dizziness and fainting due to lower blood pressure. Muscles weaken, and lanugo hair may develop (Kunskapscentrum för ätstörningar, nd). Low estrogen prevents the acquisition of peak bone mass and can lead to osteopenia and osteoporosis. In female athletes, the risk of stress fractures is 2.4–4.9 times higher than in healthy peers (Chen et al. 2023).

Weight loss-related amenorrhea is defined as the cessation of menstrual periods for >6 months following a short-term weight loss >10–15% of the standard body mass, and mainly occurs in adolescents and women of reproductive ages. Extensive research has shown that energy balance is closely linked to the reproductive system (Chen et al., 2023). The fundamental cause of this type of amenorrhea is a negative energy balance, where energy expenditure exceeds the dietary intake. HPO Suppression: When energy is scarce, the brain disrupts the pulsatile release of gonadotropin-releasing hormone (GnRH). This leads to low levels of follicle-stimulating hormone (FSH) and luteinizing hormone (LH), resulting in anovulation and hypoestrogenism (low estrogen levels). The Role of Leptin: Leptin, a hormone produced by fat tissue, acts as a permissive factor for reproduction where it bridges nutritional status and hormonal activity. During weight loss, the leptin levels drop, signaling the hypothalamus that energy reserves are insufficient to support a pregnancy, which subsequently shuts down the reproductive system. Beyond infertility, patients may experience shrunken breasts, urogenital mucosa atrophy, low libido, and painful intercourse (dyspareunia) (Chen et al. 2023).

Elaborating further National eating disorder association (nd) adds on the consequences of electrolyte imbalance, dehydration, and laxative dependency, there are many side effects. Electrolyte and mineral imbalances can significantly disrupt bodily functions. It has also been shown that electrolytes

and minerals like sodium, potassium, magnesium, and phosphorus are crucial for maintaining proper nerve and muscle function, including the muscles of the colon and heart. A disruption in the levels of these substances can lead to malfunctioning of these vital organs, potentially causing severe health issues. Severe dehydration from laxatives poses serious health risks, it can trigger symptoms such as tremors, weakness, blurred vision, and fainting. In more severe cases, dehydration can lead to kidney damage and even death, often necessitating immediate medical intervention. Laxative dependency is a consequence of laxative overuse. With prolonged misuse, the colon can become desensitized to standard dosages, requiring progressively higher amounts to stimulate bowel movements. Internal organ damage can arise from laxative abuse, leading to various complications. These include a stretched or "lazy" colon, colon infections, irritable bowel syndrome (IBS), and, in rare instances, liver damage. Moreover, chronic laxative abuse may elevate the risk of colon cancer (National eating disorder association., nd).

Treatment methods

Socialstyrelsen (2024) has made the document "National Guidelines 2024: Eating Disorders" which provides recommendations on specific treatments for AN The guidelines are aimed at decision-makers and managers within healthcare and social services in Sweden. They address both children and adults with AN and atypical AN (Atypical anorexia nervosa being when the patient meets the criterial for AN while still being at a considered normal BMI) (Socialstyrelsen, 2024). Psychological treatment methods include Family-Based Therapy (FBT), Eating Disorder-Specific Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), and Motivational Enhancement Therapy (MET). Family-Based Therapy (FBT): Most commonly, for children and adolescents with AN and atypical AN.

FBT is a manual-based therapy where caregivers actively participate in the treatment. This utilizes the caregivers' resources as support in the treatment. The goal of FBT is to help the family take control of the child's eating and support the child/adolescent in regaining a healthy weight. For young adults (18–25 years), age-adapted family-based therapy may be offered if deemed appropriate based on the family situation. This form of therapy can facilitate the transition to adult psychiatric care at the age of 18 for some individuals. Eating Disorder-Specific Cognitive Behavorial Therapy (CBT): Offered to adolescents (13–17 years) and adults with AN and atypical AN CBT is a therapy that focuses on identifying and changing thoughts, emotions, and behaviours that maintain the eating disorder. The eating disorder-specific CBT is specifically designed to address the challenges associated with eating disorders. The goal of eating disorder-specific cognitive behavioural therapy is to influence behaviours that sustain the eating disorder. For adolescents, it may be appropriate for close relatives to participate in the treatment. This method is primarily suitable for adolescents (13–17 years) if it is deemed appropriate based on maturity and family situation. It may be relevant when conditions for family-based therapy are lacking or if family-based therapy has not been effective.

Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET): May be considered as an addition to other treatments for adolescents and adults with AN and atypical AN. MI and MET are conversational methods aimed at increasing the patient's motivation for change and treatment. If the chosen treatment has not had sufficient effect, MI or MET may be an alternative. Working with alliance and motivation is a fundamental component of many treatment programs (Socialstyrelsen, 2024, p. 73). Socialstyrelsen (2024, pp. 82-87) mentions that pharmacological treatment with SSRI medication may, in exceptional cases, be considered as an addition to treatment if other interventions have not been effective in adults. However, this should be done after an individual assessment. Treatment of severe and long-term AN: Offer individualized support with a focus on quality of life while waiting for the person to become motivated to gain weight. This may involve regular check-ups
and support measures such as housing support workers or a contact person (Socialstyrelsen, pp. 82-87). Socialstyrelsen also mentions that voluntary hospitalization should be offered as part of the care plan.

It is important to ensure that healthcare personnel have the right competence, including knowledge of comorbidities and how the eating disorder affects daily life. Staff should also have access to consultation with experts in psychiatry. Another point mentioned is that a systematic assessment of other psychiatric problems should be offered in parallel with eating disorder treatment if the patient has not achieved sufficient effect from the treatment. Additionally, treatment for emotional regulation difficulties should be provided if the patient has not benefited enough from eating disorder treatment.

Examples of such treatments include Dialectical Behavior Therapy (DBT) and Mentalization-Based Therapy (MBT). The guidelines also emphasize the importance of adapting care to the individual and ensuring a structured transition between pediatric and adult healthcare. Furthermore, the significance of collaboration with other services, such as those providing care for obesity, and ensuring support for managing daily life is highlighted Socialstyrelsen (2024, pp. 82-87). According to McClelland et al. (2016) is transcranial magnetic stimulation (rTMS) considered a viable treatment option by individuals with AN. rTMS is a noninvasive neuromodulatory technique that targets neural substrates thought to be involved in AN, specifically the fronto-striatal circuits and the dorsolateral prefrontal cortex (DLPFC). When applied to the DLPFC, which has a key role in self-regulatory control mechanisms, rTMS delivers a magnetic field that in turn induces an electrical current in the brain to alter neural activity. The excitatory stimulation of the PFC can temporarily improve AN symptoms that are linked to impaired inhibition and cognitive inflexibility (McClelland et al., 2016).

Involuntary Treatment (IT) is used as a treatment method for a subset of seriously ill patients with AN who refuse treatment, where specific measures may include involuntary hospitalization, nasogastric tube feeding, restraint, medication and electroconvulsive therapy (ECT), involuntary treatment for somatic illness, mechanical restraint (including belts, straps and gloves), physical restraint, locked wards, constant observation and sedative medication (Mac Donald et al., 2023). Stallman and Gupta (2025) define involuntary care as a coercive process that aims to stabilize the health and well-being of the individual while minimizing the risk of harm. This form of care involves mandatory assessment and/or treatment of mental health for individuals who are considered incapable of consent due to impaired decision-making capacity. Involuntary care thus deviates significantly from the normal model of care, as treatment is administered without the individual's consent. Involuntary care is governed by specific legislation and is based on a risk assessment of the individual's perceived risk of harming themselves or others. It is typically only applied under the condition that the individual has a serious mental illness, is judged to be at significant risk of harming themselves or others, and no less restrictive treatment options are available (Stallman & Gupta, 2025).

Genetics links to Anorexia Nervosa

It's been investigated about the genetic risk factors for AN and to detect its genetic associations with other traits. Researchers conducted a genome-wide association study (GWAS) and identified eight significant loci associated with AN. The study also used eQTL analyses and chromatin interaction studies to link the identified loci to specific genes. For the multigenic loci (1 and 3), it was difficult to identify individual genes due to the high density of genes and interactions in these regions. However, the study confirmed four single-gene loci (2, 4, 5, and 6) through eQTL analyses and chromatin interaction studies, which strengthens the hypothesis that these genes (CADM1, MGMT, FOXP1, and PTBP2) may play a role in the etiology of AN. The authors suggest that the results are important for restructuring the view of AN as a metabo-psychiatric disorder. They emphasize that a low BMI has traditionally been regarded as a consequence of psychological factors, but this approach has not led to effective treatments. Instead, they propose that metabolic dysregulation may contribute to the difficulty in maintaining a healthy BMI in individuals with AN, even after treatment. Therefore, the study encourages considering both metabolic and psychological factors when developing new treatment strategies for

AN. The study also identified genetic correlations with metabolic traits, suggesting that AN shares genetic variation with these phenotypes independently of BMI. (Watson, et al., 2019).

The nursing strategies and responsibilities

Historically, nursing care for AN has been dominated by a biomedical model where the primary focus was on weight restoration, bed rest, and strict dietary regimens. This perspective meant the patient was often perceived as a means to an end (weight gain) rather than as a unique individual.
The transition from 'doing for' the patient to 'working with' the patient represents a necessary paradigm shift in nursing (Holyoake & Jenkins, 1998).

Although medical treatment focuses on weight restoration, the risk of relapse remains high, estimated at 30–50%. Berends et al. (2012) argue that there is a significant gap in nursing practice regarding structured methods for relapse prevention. Because of their close and intensive professional relationship with the patient, nurses are in a unique position to lead this work. Effective nursing care requires a partnership where the nurse and patient together identify individual triggers and early warning signs (Berends et al., 2012).

Nurses play a critical role in monitoring the physical health of patients with AN, requiring a sharp "clinical eye" to detect asymptomatic somatic complications. Essential procedures include blood tests, ECGs, and vital sign monitoring to identify common abnormalities such as bradycardia and hypotension, which often necessitate the use of specialized equipment like child-sized blood pressure cuffs. Cardiovascular stability must be closely assessed via ECG for indicators like T-wave flattening or prolonged QTc segments. Furthermore, because starvation lowers baseline body temperature, nurses must recognize that patients may be febrile at lower temperatures than normal, especially as an immunocompromised state increases the risk of rapid infection progression (Foá et al, 2019). Nurses must be vigilant for early warning signs of AN, as patients often present with non-specific complaints and initial denial of their disorder. Beyond evaluating medical risks, the nursing assessment must proactively identify maladaptive behaviors, such as food diversion, purging, or over-exercising, while utilizing a comprehensive systems review to understand the patient's history. Regardless of the initial admission criteria, a thorough physical and behavioral assessment is essential for early identification, preventing serious complications, and improving the patient's overall prognosis.
A basic physical assessment and history of illness provide important information on the patient's health. While some assessment findings might appear abnormal compared to those of a healthy individual, they may be typical for someone with an eating disorder. A thorough review of all systems should be included in the nursing assessment of a patient with a suspected eating disorder, regardless of the patient's admission criteria (Hovde., et al. 2023).

Effective management of eating disorders, particularly AN, necessitates a multidisciplinary approach involving a team of specialists such as psychiatrists, psychologists, and nutritionists, alongside various interventions including outpatient therapy, day-time centers, and hospitalization. Within this multifaceted framework, nurses play a central role in patient care, functioning as a vital link between the hospital and the community (Foá., et al (2019); Davén., et al (2022). Nursing is not only about managing physical symptoms, but also about addressing patient resistance and building a therapeutic alliance. In the treatment of anorexia, nurses undertake several key responsibilities, ensuring that care is delivered with appropriateness and adequacy while demonstrating high professionalism and strong relational skills. This involves a thoughtful consideration of established protocols and procedures, tailored to meet each patient's unique needs. Nursing care for individuals with AN is a highly complex and demanding field that requires a unique integration of both somatic and psychiatric expertise. Nurses play a central role in patient care, functioning as a vital link between the hospital and the community. A fundamental aspect of this role is the ability to "enter the patient's world of experience,"

which involves gaining a deep understanding of the patient's underlying anxiety, rigidity, and ambivalence. Rather than viewing a patient's refusal to eat as mere resistance, the nurse must recognize it as a manifestation of extreme anxiety and a desperate need for control to avoid psychological pain (Brinchmann et al., 2024).

Holyoake & Jenkins (1998) also highlights that this holistic approach requires the nurse to enter the patient's world of experience to understand the underlying anxiety and the need for control, rather than viewing food refusal merely as resistance. By establishing a care relationship based on trust and partnership, the nurse can reduce the sense of powerlessness that often arises in encounters with strict treatment regimens. Given that the incidence of AN is highest among young women with figures as high as 270 per 100,000 person-years in certain Nordic countries it is especially critical to develop nursing models that support the individual's autonomy and identity development (Holyoake & Jenkins, 1998). A fundamental aspect of the nurse's role is building trust through the establishment of trusting relationships, facilitated by data collection and open communication with both the patient and their family. The nursing care encounter in psychiatric settings is a human-to-human relationship often experienced by staff as an "emotional roller coaster". Nurses must navigate conflicting emotions, balancing the initial shock of seeing a severely emaciated body with deep sympathy and a professional desire to help. A central nursing challenge is to see the person behind the illness, moving beyond physical metrics like low weight to understand the patient's unique suffering. If nurses become overwhelmed by these emotions or feelings of powerlessness, there is a risk of the encounter becoming paternalistic, which can hinder the therapeutic alliance. To maintain professional steadiness and avoid moral distress, nurses rely on team support and structured routines to provide security while safeguarding the patient's autonomy (Davén, et al (2022).

Core concept

In this study, the core concept is person-centered care.

Person-centered care

Person-centered care is described as an approach that focuses on the person with an illness, rather than the illness in the person. It is also described as establishing a partnership with the patient and planning care together, involving them in the planning of their care (Berg & Lepp, 2022 p. 383). For care to become patient-centered, we have to go beyond simply hearing the patient's story, reflecting on it, and summarizing it. It is important to establish specific, measurable goals together, meticulously document them, and consistently monitor progress. It is the healthcare professional's task to Work together with the patient to develop a comprehensive health plan that acknowledges the resources available, addresses their identified needs based on their personal narrative, and incorporates relevant clinical examinations and tests. It is also important to clarify what is most important to the person here and now, as well as how involved they want to be in decisions and plans for care and treatment. The healthcare system should provide continuous support, so that patients are not abandoned during transitions, such as hospital discharge. Primary care providers should be well-informed about the patient's history, treatment goals, and plan of care (Holmstöm, 2022, p. 435).

Problem statement

Anorexia Nervosa (AN) is a complex and life-threatening psychological disorder characterized by the highest mortality rate of any psychiatric illness. Despite the severity of the condition, traditional treatment models frequently prioritize physical stabilization through weight gain and BMI monitoring. Within nursing, this poses a significant challenge; the nurse must balance a "clinical eye" for somatic risks, such as refeeding syndrome and vital signs, with a deep psychiatric understanding of the patient's internal world of anxiety and ambivalence. The problem arises when the biomedical focus is prioritized at the expense of the patient's perspective, which can lead women to experience a loss of autonomy, identity, and trust in caregivers. There is a notable knowledge gap regarding how nurses can reconcile the necessity of maintaining treatment frameworks with a person-centered nursing relationship that validates the individual behind the diagnosis. Given that the incidence of AN is significantly highest among young women, exploring their specific lived experiences is crucial for enhancing nursing competence and preventing the cycle of relapse caused by failures in the continuity of care. The study is needed to understand how to move from a purely medical focus to a care model that supports identity development and long-term recovery.

AIM

The aim of this study was to evaluate and synthesize qualitative studies exploring women's lived experiences when in treatment for Anorexia Nervosa.

METHOD

Design

In this study, the authors undertook a broad qualitative literature review, systematically gathering, evaluating, and synthesizing existing research to address their specific research questions. In accordance with Polit and Beck, a literature study was selected to evaluate and synthesize existing research. By systematically compiling data from previous studies, the authors aim to provide a comprehensive synthesis of current knowledge and highlight specific knowledge gaps that justify the need for the present study (Polit & Beck, 2021, p. 82–83). Forsberg and Wengström (2016, p. 44) explain that a qualitative approach is used when describing human subjective experiences of a phenomenon. This approach is consistent with the present study, as the aim is to evaluate and synthesize qualitative studies exploring women's lived experiences when in treatment for Anorexia Nervosa. The methodology was inspired by Polit & Beck's flow of tasks in a literature review which is a nine-step model as modified and illustrated to match our own study design in Figure I. The initial step in Polit & Beck's flow of tasks involved clearly defining the study's purpose and research questions (Polit & Beck, 2020, p. 85).

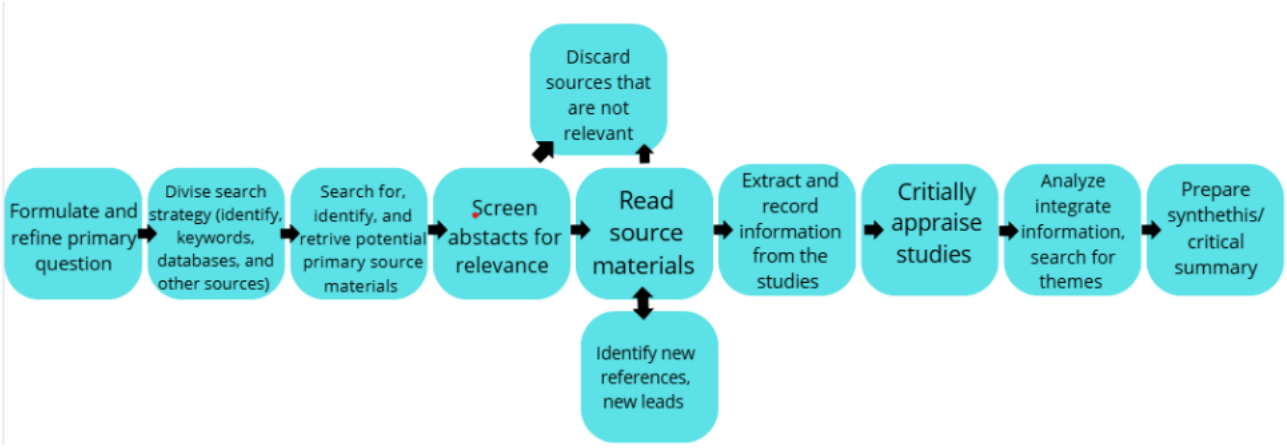

Figure I. Modified flow of tasks in a literature review model (Polit & Beck, 2021, p. 85)

Sample

In the second step, a qualitative selection process was conducted for identifying appropriate sources of information for the study (Polit & Beck, 2021, p. 497). Since this is a literature review, the source material consists of scientific articles. Consistent with step two, the selection process started by identifying suitable search terms and relevant databases. Additionally, to refine the search, it was essential to define the study population through inclusion and exclusion criteria (Polit & Beck, 2021, p. 261). This involves specifying who is included and excluded from the study. It was of high importance to use inclusion criterias as the researcher needed to establish clear inclusion criteria to identify relevant data and the correct population (Polit & Beck, 2021, p. 261). In this study, the inclusion criteria that the authors applied for the selection of articles were: Women (Late adolescents and adults), who have been in treatment for Anorexia Nervosa or currently is in treatment for the disorder, qualitative original articles to answer to the aim of this study, written in English, and articles from the years 2020–2025 (**Table I**). Exclusion criteria refer to criteria for excluding individuals or data from the selected population and target group. The aim is to ensure that only relevant participants or results are included in the study (Polit & Beck, 2021, p. 786). The exclusion criteria that the authors applied in the study's

selection were: articles featuring the perspective of healthcare professionals, articles with systematic literature reviews, articles that did not report ethical approval, articles where the authors did not have access to the full text, and not peer reviewed articles.

Table I . Inclusion and exclusion criteria.

Category	Inclusion criteria	Exclusion criteria
Population	Women (late adolescents and adults) currently undergoing or having undergone treatment for AN	Men, children, or studies focusing solely on the perspectives of healthcare professionals
Study Design	Original scientific articles using qualitative methodology	Systematic literature reviews, quantitative studies, or articles that were not peer-reviewed
Timeframe	Articles published within the last five years (2020–2025)	Articles published more than five years ago
Language	Articles written in English	Articles written in languages other than English
Ethics & Access	Articles that explicitly reported ethical approval and were available in full text	Articles without reported ethical approval or where full-text access was unavailable

Data collection

Based on the aim of the study and following **step three** of the literature review model, the selected databases, CINAHL and PubMed, are searched (Polit & Beck, 2021, p. 85). To maximize the breadth of search results, a combination of controlled vocabulary (MeSH in PubMed and CINAHL Subject Headings) and free-text searching is employed. The final search string used in both databases is: (Anorexia Nervosa OR Anorexia) AND (Women OR Patient OR Female) AND (Experience OR Lived Experience OR Perspective OR View) AND (Treatment OR Recovery OR Therapy OR Care). Each keyword search is initially performed independently before the Boolean operator "AND" is applied to narrow the search, requiring all specified terms to be present, while "OR" is used to expand the search (Polit & Beck, 2021, p. 89).

The screening process was conducted in several stages to ensure high transparency and replicability. First, the authors jointly performed the initial database search. Subsequently, all titles and abstracts were screened independently by each author to reduce subjective bias and ensure confirmability. Any discrepancies regarding the inclusion of specific articles were resolved through joint discussion until consensus was reached. The screening followed a hierarchical process: starting with a review of titles, followed by abstracts in **step four**, and finally, a full-text examination of potential articles in **step five**. This systematic selection ensured that the remaining articles met all predefined inclusion and exclusion criteria.

Step six consisted of sorting and selecting relevant information from the articles retrieved via CINAHL and PubMed. A total of twelve articles were identified that were deemed useful for the study, six from PubMed and six from CINAHL. After the systematic selection process was completed, the authors created an article matrix (Appendix II). The purpose of the matrix was to collect and organize the collected information in a structured and clear manner. The article matrix allowed critical elements such as author, year, country, aim, method, selection, and the study's central results to be presented clearly.

The matrix served both as a tool for creating order and as a starting point for the continued thematic analysis (Polit & Beck, 2021, pp. 100–101).

Data analysis

Step eight involved the authors analyzing and integrating the information from the selected articles. The work was conducted as an inductive thematic analysis, where recurring patterns, variations, and knowledge gaps were identified to create a holistic picture of existing research. This process is similar to qualitative data analysis and aims to synthesize central themes that together describe the current state of knowledge and contribute to answering the purpose of the study (Polit & Beck, 2021, pp. 105–106).

Quality Appraisal

The authors conducted a critical appraisal to evaluate the quality of all included articles (Polit & Beck, 2021, p. 105). Twelve of the articles were assessed using the Swedish National Board for Medical and Social Evaluation (SBU) review template for qualitative studies (SBU, 2022). SBU review templates were used to appraise that published studies maintained an acceptable scientific quality. Through this assessment, the authors aimed to evaluate that the selected articles met reasonable quality requirements. The authors decided to only include articles of moderate or high quality to reduce the risk of random errors. To provide a high level of scientific evidence, the authors established the following criteria for quality levels: Articles were classified as high quality if they were judged to have only minor or insignificant methodological flaws. This meant that the study demonstrated a clear and consistent link between the aim, methodology, and analysis, provided a transparent description of the participants and data collection, and addressed researcher reflexivity. Articles were classified as moderate quality if they presented some methodological flaws that were deemed not to compromise the overall credibility of the findings. This typically involved minor deficiencies in one area, such as limited details regarding the researcher's background or the validation of findings, but where the results were still considered valuable and trustworthy. Articles with major methodological flaws (two or more significant deficiencies) were excluded from the synthesis to ensure the reliability of the results.

The appraisal process was conducted systematically: each author first performed an independent assessment of the articles using the SBU template. Subsequently, the authors compared their results and engaged in joint discussions until a consensus was reached on the final quality grade for each study. Following this process, seven articles were assessed as high quality and five as moderate quality (Appendix I).

Thematic Analysis

To analyze the qualitative data collected from the selected articles, the authors employed thematic analysis. This method was suitable because the goal was to identify recurring themes and patterns in the material, which were then compiled to answer the study's research question. The analysis was structured using the six-phase framework described by Braun and Clarke (2006). Table I illustrates these phases, providing a brief summary of each phase based on Braun and Clarke's (2006) description. The description outlines the process of thematic analysis, which involves six central stages. Step one Initially, was thoroughly familiarizing oneself with the material. This involved transcribing data if necessary, followed by a careful reading of the data where initial thoughts and ideas were continuously noted. The aim is for the researcher to achieve a deep understanding of the content. Step two focuses on generating initial codes. Here, a systematic coding of interesting aspects in the data occurs across the entire dataset. In this stage, relevant data linked to each code is compiled. In Step three, searching for themes, the various codes were organized into potential themes, and all relevant data for each identified theme was gathered. Step four, reviewing themes, the extent to which the themes align with the coded extracts (level 1) and the entire dataset (level 2) was examined. During

this phase, a thematic map of the analysis also developed. Step five involved defining and naming themes. Each theme was refined through continued analysis. This included clearly defining each theme and determining the overall narrative that the analysis presented. Step six the report is produced. This constituted the last opportunity for analysis. Here, the researcher selected vivid and compelling examples from the material, conducted a final analysis of these extracts, and linked the findings back to the research question and relevant literature. This lead to the creation of a scholarly report (Braun & Clarke. p 87, 2020). This brought the authours back to step nine of Polit and Beck which is about compiling a result. Our choosen themes and and subthemes where compiled into a result matrix and in flowing text with selected articles. The authors got a clear overveiw and compilation of the results from each article (Polit & Beck, 2021, s. 100).

Table II. Examples from the authers analysis process, with part of text that answers the aim, code, subthemes, themes. According to Braun & Clarke (2006).

Part of text that answers the aim	Code	Subthemes	Theme
"The first person who actually listened to me. And listened to what I was saying as me, rather than assuming that everything that came out of my mouth was anorexia."	Separation / Validation of Self	Deeper than the weight	Relational Foundations and the Person-Centered Nursing Approach
		Separation of individual/condition	
		Recovery-promoting relationship - Valuing patient experience	
Over two-thirds (71%) spoke about interferences with recovery. Two individuals cited insufficient access to desired treatment resourcespost-hospitalization.	Lack of transition support	Lack of continuity in care transition	Continuing of care
		Hopeful Identity and Self-Care	
		Improving quality of life	

Ethical considerations

Although this study was conducted as a qualitative literature review and did not involve direct contact with human participants, it followed the ethical guidelines for good research practice (Vetenskapsrådet, 2017, p. 75). A central ethical responsibility when conducting a literature synthesis is to ensure the integrity and ethical standards of the primary research being reviewed. To address this, a strict inclusion criterion was established, requiring all selected articles to have explicitly reported ethical approval from an ethics committee. Furthermore, the authors maintained ethical reflexivity throughout the process to ensure that the sensitive lived experiences of women with Anorexia Nervosa were represented honestly and respectfully. The authors strived to present the findings of the original researchers accurately, avoiding any distortion of the patients' narratives or the clinical findings. By critically evaluating the quality of the material and handling the secondary data with academic integrity, the authors aimed to uphold the principles of good research practice while contributing to the knowledge base of nursing care (Vetenskapsrådet, 2017, p. 75).

RESULTS

Methodological characteristics and quality of included studies

The results of this literature review are based on twelve original scientific articles using qualitative methodology. The studies have a geographical spread and were conducted in the USA (4), England (3), Australia (3), and Denmark (2). All included articles focus on women's experiences of treatment for AN, with participants ranging from late adolescent girls to adult women. The data collection methods in the included studies consist primarily of semi-structured interviews, conducted either individually (face-to-face or online) or in focus groups. One study also utilized the specific "Voice Dialogue" method to explore patients' relationships with their eating disorder voice. The analysis methods in the studies included thematic analysis, interpretative phenomenological analysis, and content analysis.

During the quality appraisal, which was performed using the SBU template for qualitative studies, only articles assessed as being of moderate or high quality were included. Of the twelve articles, seven were assessed as high quality (articles #1, #3, #4, #7, #9, #10, #11) and five as moderate quality (articles #2, #5, #6, #8, #12). By excluding low-quality studies, the aim has been to strengthen the credibility of the results and ensure that the synthesis is based on scientifically sound research.

Results of the thematic analysis

The thematic analysis of the twelve included articles resulted in two main themes and six subthemes that describe women's lived experiences of treatment for AN. An overview of the results is presented in Table III, followed by a detailed description of the findings.

Table III. Provides an overview of themes and subthemes

Theme	Subtheme
Relational Foundations and the Person-Centered Nursing Approach	Deeper than the weight
	Separation of individual/condition
	Recovery-promoting relationship - Valuing patient experience
Continuing of care	Lack of continuity in care transition
	Hopeful Identity and Self-Care
	Improving quality of life

Relational Foundations and the Person-Centered Nursing Approach

The theme Therapeutic relationships highlights the pivotal finding that the quality of the therapeutic relationship and the approach taken by staff are frequently reported as more critical to the treatment experience than the specific therapeutic methodology employed. A strong, trusting relationship is deemed essential for patient engagement and acceptance of care., while patients in treatment have struggled with the loss of autonomity. Several articles underscore that building a trusting relationship first is a crucial activity in care. The theme also describes that the treatment often placed an excessive emphasis on weight gain and a goal BMI, instead of treating the underlying issues, which could reinforce anorectic behaviours in patients.

Deeper than the weight

Multiple studies illustrated that patients felt their treatment focused too narrowly on quantitative measures, perceiving this as harmful and reinforcing maladaptive cognitions. Participants criticized the conventional biomedical imperative, the focus on weight gain, for being executed to the exclusion of addressing the full spectrum of consumer needs (Zugai et al., 2023; Andersen et al., 2021; Curry & Andriopoulo., 2023). The sentiment that health should not be strictly quantified by BMI is encapsulated in majority of articles. This reliance on weight as a marker for the legitimacy of care created significant barriers. On the other spectrum, Findings also show that patients with Atypical Anorexia experienced weight stigma and felt dismissed when clinicians failed to recognize the severity of their condition because they were "not underweight enough to need treatment," (Harrop et al. 2024) restricting their access to vital care before the situation gets to a point where it **harms** the physical. Participants felt their weight was a pivotal factor in their ability to access treatment, and that they had to have a lower BMI to be taken seriously and gain support. (Harrop et al., 2024; Curry & Andriopoulo., 2023). Furthermore, individuals living with Severe and Enduring Anorexia Nervosa, expressed profound frustration with treatments that only focused on eating and weight gain (Cummings et al., 2023). It was found that patients rejected specialized treatment offers because they believed the treatment was solely focused on Eating Disorder (ED) symptoms and weight gain and would be insufficient to address their need for "more therapeutic help and a better understanding of the underlying causes of their ED". It was noted that breakthrough moments were reported to occur when staff engaged with them as a human with feelings and showed interest in the source of their emotional struggles, rather than just treating the physical symptoms (Zugai et al., 2023).

Separation of individual/condition

A hallmark of a positive relationship was the ability of healthcare professionals to separate the individual and the AN, to view the patient as an whole person rather than solely defined by the illness. Conversely, the damaging assumption that everything the patient say is the AN speaking is reported to be a significant source of frustration and invalidation for patients (Rankin et al., 2025; Curry and Andriopoulou's., 2023). Many of the patients described that trustworthy therapeutic relationship is characterized by specific collaborative and empathetic behaviors from the staff. A positive therapeutic relationship was characterized by empathy and sincere care, which established a feeling of safety and comfort (Zugai et al., 2024; Curry & Andriopoulou., 2023; Holmes et al., 2021). When caregivers demonstrated empathy and validated the patients feelings, they felt safe enough to be vulnerable. This resulted in an experience of being cared for rather than controlled or coerced. The feeling of being genuinely cared for reassured the consumer about the safety of eating and weight gain. Staff who could separate the individual from the disease, trust the patient's experiential narratives, and treat them with respect were highlighted as recovery-promoting (Zugai et al., 2024; Chang et al., 2023; Andersen et al., 2021). Patients need to feel safe and unconditionally valued as a person (Andersen et al., 2021; Rankin et al., 2025; Cummings et al., 2023).

Trust and respect are seen as fundamental to building the treatment alliance and perceived lack of trust towards the patients in inpatient settings resulted in erosion of self-esteem and demotivation (Holmes et al., 2021). Furthermore, findings show that while many patients reported common issues regarding clinicians use of power such as unnecessary restriction of autonomy and excessive use of coercion, the perceived experience of this power was dependent on "the strength of the interpersonal relationship". Patients valued collaboration, reciprocity, understanding, and respect from caregivers (Zugai et al., 2024). Trust is necessary for guiding changes in the patient's behaviors and is linked to increased motivation to challenge their eating disorder, Positive encounters make patients feel understood, safe, and valuable (Chang et al., 2023; Chua et al., 2022). For patients who had been through involuntary treatment, loss of control was experienced intensely negatively. The loss of control

was identified as an important part of Anorexia. Involuntary treatment also entailed a loss of meaning of life that AN provided as a coping strategy, and the resulting lack of any substitute could contribute to suicidality. In these moments, some participants found that involuntary treatment could help an internal battle against AN. Involuntary nasogastric tube feeding specifically helped them avoid the responsibility for getting nutrition, thereby placing the responsibility outside themselves. One participant found the process extremely relieving because they did not have to take a stand on anything regarding food (Mac Donald et al., 2023). The use of coercive methods, the hard approach, such as threatening to place a NG tube (Chang et al., 2023) can lead to patients being suspicious of each other and not being able to fully trust healthcare professionals, Patients reported feeling degraded and believed they were being treated disrespectfully when decisions were made without their involvement (Chang et al., 2023; Andersen et al., 2021).

Recovery-promoting relationship/valuing patient experience

The recovery-promoting relationship acts as a mirror where the patient, previously distorted and reduced by their illness, sees their whole person reflected back by a trusted and competent clinician. This enables the patient to shift from viewing themselves as a defective diagnosis to viewing themselves as a valued partner in their own healing. A found key element of a recovery-promoting relationship is the genuine valuing of the patient's voice and identity. It was also found that relationships with other patients were valuable for creating solidarity, support, and mutual recognition (Holmes et al., 2021; Rankin et al., 2025). Some environment inpatient settings were harmful, leading to sick mentality of competition with peers (Cummings et al., 2023). The collective residential milieu was often perceived as a formative experience that was central to the recovery narrative. Some patients expressed negative experience with carers that lacked understanding and who seemed to not want to advance their knowledge about Anorexia Nervosa. Access to staff with lived experience, such as peer support workers or recovery navigators was seen as a substantial asset (Curry and Andriopoulou., 2023; Rankin et al., 2025). These staff members provided hope by demonstrating that it was possible to exist beyond the eating disorder. Lived-experience practitioners are noted for their unique ability to use experiential knowledge to connect with service users, embody hope, and normalize service users' experiences, Dual-experienced professionals are recognized for their unique ability to use experiential knowledge to connect with service users, embody hope, and normalize service users experiences. Participants maintained hope for improving their quality of life but also stressed the danger of provider-induced hopelessness, noting that hospice-oriented care felt like it lowered the bar for their future. They relied on providers to "hold hope" for them during difficult periods (Cummings et al 2023; Curry and Andriopoulou., 2023; Rankin et al., 2025).

Continuing of Care

The theme Continuity of Care addresses the deeply ingrained structural and relational challenges patients face during the critical period of transition from intensive treatment back into their daily lives, thereby underscoring the necessity of persistent and genuinely integrated support. This transition is often described as an abrupt break, where structural failures compound the psychological injuries suffered during inpatient care, severely limiting the possibility of long-term recovery, and increasing risk of relapse. The theme also show finding identity describes the profound process through which individuals strive to reclaim their personal self from the dominating grip of an eating disorder. The theme highlights the complex inner journey involved in developing a new or rediscovered identity, creating meaning and direction forward, and achieving psychological separation from the voice of the illness. It also includes the development of strategies for self-care and therapeutic self-management that support recovery.

Lack of continuity in care transition

Many of the women who have been treated for anorexia nervosa experience a lack of continuity during the transition of care when moving from inpatient to outpatient treatment or being discharged (Rankin et al., 2025; Cummings et al., 2023; Pagano et al., 2023; Harrop et al., 2024; Zugai et al., 2024). Many participants reported that they had difficulty or were unable to access and/or connect with sufficient community-based treatment support when they returned to their community after discharge (Cummings et al., 2023; Rankin et al., 2025).

Experiences during inpatient treatment can create long-term barriers to seeking follow-up care (Zugai et al., 2024; Holmes et al., 2021; Andersen et al. 2021). Coercion and mistrust during inpatient care became a barrier to future engagement, where negative experiences during hospitalization or intensive treatment reduced patients own willingness to seek and participate in continuous care options. Patients found themselves in several situations where healthcare staff abused or exploited their position of power, such as with unjustified restrictions of autonomy, and that coercive measures could be taken to an extreme. This included the use of physical force, compulsory medication, and explicit threats of violence and punishment, which were reported as abuse of power (Zugai et al. 2024). The majority of women who abstained from specialized treatment showed that perceptions of rigid standard procedures as well as distrust and fear were significant barriers to starting care (Andersen et al., 2021).

Discharge Planning and preparation offered in intensive settings was often deemed inadequate for community reintegration, particularly because the focus was too narrow (Zugai et al., 2024; Rankin et al., 2025; Cummings et al., 2023; Pagano et al., 2023). The intensive focus on weight gain during hospitalization was found to be of limited long-term value. This limitation was attributed to the fact that the focus on weight failed to sufficiently prepare patients for the transition back to community life. Underlying psychological needs were often left unaddressed, patients were discharged with the same maladaptive coping mechanisms they had before admission. This failure in discharge preparation led to regression and subsequent readmissions (Zugai et al., 2024). The patients extensive treatment history was described as a cycle resembling a revolving door, with steps toward recovery followed by periods of medical instability. The transition felt abrupt, and patients reported that there is no step down to the community. Patients reported having difficulties accessing adequate community-based support after returning to the community following discharge. Specialized care for eating disorders was perceived as very difficult to access unless it involved inpatient care (Cummings et al., 2023). The transition from inpatient to outpatient care was challenging and could feel like being left alone (Rankin et al., 2025). The practical requirements for new treatments and the need for therapeutic integration pose logistical challenges for continuity of care. Some patients had access to telehealth, and its availability was positively seen as a beneficial "step-down" approach after intensive treatment. Telehealth was perceived as functioning as an intermediate level of care for patients who were at a partially inpatient program level and regular outpatient services (Pagano et al., 2023).

A recurring obstacle for many women was their socioeconomic and structural barriers (Rankin et al., 2025; Pagano et al., 2023; Harrop et al., 2024). For some, insurance was a barrier that limited their access to desired care resources after hospital discharge. Some lacked approved insurance, and as a result, treatment was abruptly discontinued without steps or support between inpatient and outpatient care (Pagano et al., 2023; Harrop et al., 2024). Inadequate insurance coverage also hindered access to higher levels of care, as insurance coverage ended too early while higher levels of care were still needed. One patient questioned why, after disclosing severe anxiety and suicidal thoughts, they were moved to a lower level of care by their insurance (Harrop et al. 2024). Additionally, participants who left residential treatment early or experienced relapse often cited financial reasons as a decisive barrier to either extending their stay or considering readmission (Rankin et al., 2025). A narrow focus on immediate stabilization during intensive treatment, without sufficient psychological preparation for

life outside the unit, resulted in patients relying on the hospital structure, leading to relapse upon discharge and subsequent readmission. (Zugai et al., 2024; Cummings et al., 2023; Mac Donald et al., 2023; Harrop et al., 2024).

Many patients have a long history of multiple treatment episodes, with several hospitalizations, which suggests a frequent inability to maintain recovery outside the intensive treatment environment. Specifically regarding the transition, several patients noted that the transition from inpatient to outpatient care is particularly challenging and a triggering factor for relapse (Cummings et al., 2023). Dependence on high-intensity, compulsory care could sustain the cycle the participants described that involuntary treatment (IT) could continue because it was the only way for the participant to legitimize their eating, suggesting a dependence on compulsive external controls that are immediately lost upon discharge to a lower level of care. Participants also felt that IT often left a negative imprint that lasted long after the experiences, leading to persistent attempts to avoid certain IT measures. Such avoidance of necessary follow-up care contributed to the cyclical nature of relapse and readmission (Mac Donald et al., 2023).

Hopeful Identity And self-care

The internal compulsion of the eating disorder voice (EVD) is often dominated by a hostile, internally created narrative that generates overwhelming inner pressure, which many experience as a form of coercion (Chua et al., 2022; Mac Donald et al., 2023; Holmes et al., 2021). A proportion of individuals with anorexia nervosa describe the experience of the EVD as characterized by a hostile commentary related to eating, body shape, and weight, perceived as internally created yet still separate from the self (Chua et al., 2022). And patients described this internal compulsion as a "battle in their minds against AN" (Mac Donald et al., 2023). Many women felt that every choice they made was always assumed to be chosen by the eating disorder itself, which reduced their own sense of agency (Holmes et al., 2021).

The treatment environment often reinforces the narrative of EDV by prioritizing objective biomedical markers, thereby invalidating the patients identity and subjective experiences. Inpatient treatment often relies on the construction of the bodys biomedical landmarks (e.g., weight) as the valued markers of truth (Holmes et al., 2021; Zugai et al., 2024). This practice contributes to a systemic disqualification of voice, and patients concerns were dismissed, silenced, or ignored as pathological. Many women felt that the body was constructed as the valorised site of truth in treatment, overriding the patient's narrative (Holmes et al., 2021), which also led to women feeling invalidated and having difficulty accessing care (Zugai et al., 2024). The Voice Dialogue method is a specific form of chair work, providing a concrete mechanism for patients to separate from the EDV, understand its protective function, and develop tools to challenge it. The use of chairs and movement creates a physical and psychological boundary between the voice and the self, allowing participants to concretize, personify, and relate to the EDV as a separate entity. Several of the patients were able to feel less identified with the EDV. By allowing the EDV to speak directly, its perceived power was reduced. This also led them to explore their conflicting feelings about recovery and motivated them to challenge the eating disorder voice (Chua et al. 2022).

Several women experienced the thoughts and behaviors associated with their eating disorder as egosyntonic, and therefore as a natural part of themselves, which made both insight and efforts to change more difficult (Curry & Andriopoulou, 2023; Mac Donald et al., 2023; Zugai et al., 2024; Rankin et al., 2025; Cummings et al., 2023). They frequently reflected on the pervasive influence the eating disorder had on their lives, explaining how their identity became lost to the eating disorder (Rankin et al., 2025). This egosyntonicity contributes to patients resistance to treatment (Curry & Andriopoulou, 2023). The internal struggle caused by AN itself creates a state of internal compulsion, forcing patients to follow a strict regimen of starvation or compulsive exercise, which the women tended

to identify with and became a way of living (Mac Donald et al., 2023; Cummings et al., 2023). The eating disorder was perceived as serving several perceived benefits, such as avoiding suffering or providing a sense of accomplishment (Cummings et al. 2023). Due to the egosyntonic nature of AN, conflicts often arise between patients and clinicians as the possibility of weight gain threatens their valued thinness (Zugai et al. 2024). Many women outlined the difficulty in imagining or contemplating the concept of a life without the eating disorder, indicating that the illness felt like an integrated part of their existence (Rankin et al. 2025).

In order for life outside AN to feel meaningful, many patients expressed hope for improved quality of life, with many hoping for an ordinary life that they saw as extraordinary (Cummings et al., 2023). Despite the importance of hope, some participants admitted that they were afraid to hope due to repeated relapses (Cummings et al. 2023). Healthcare staff are described as a valuable source of hope that can motivate patients to keep fighting the illness. The realization that they had much more to offer in various ways through engagement in life outside anorexia nervosa served as a turning point in the recovery process. Finding a passion or something separate from the eating disorder to engage in (Cummings et al., 2023).

Empowerment comes through personal agency in treatment decisions, supported by concrete recovery tools and by adopting self-compassionate behaviors. Several women experienced a sense of agency by being able to choose which therapeutic components they found helpful, rather than solely relying on treatment recommendations (Pagano et al., 2023; Rankin et al., 2025; Dalton et al., 2022; Mac Donald et al., 2023). The experience of undergoing treatment on their own terms provided dignity and helped alleviate a feeling of confinement (Rankin et al., 2025). Specific self-management strategies included keeping a journal to help reduce the compulsive eating disorder thoughts and to work on examining and challenging them through fact-based reflection. Another cognitive strategy was to metaphorically imagine the brain as a radio and "turn down the volume" on the voice of the eating disorder. Listening to recovery podcasts and stories about inspiring women who had recovered were effective strategies for the women (Pagano et al., 2023). The process of letting go of compulsion was experienced as strongly linked to adopting new self-care habits, where participants consciously chose to stop punishing themselves and became more compassionate toward themselves (Mac Donald et al. 2023).

Improving quality of life

There were certain factors and mechanisms that the women with AN experienced as essentials for leading them toward recovery, improvement for quality of life, or a fundamental change away from their illness. When successfully progressing through and beyond intensive treatment, participants described a profound shift in their internal self-perception, emotional regulation, and future outlook, which affirmed an identity distinct from AN (Pagano et al., 2023; Mac Donald et al., 2023; Chua et al., 2022; Dalton et al., 2022).

A major aid in the recovery process was finding a passion, or something separate from the eating disorder to dedicate themselves to, which provided a new sense of purpose and motivation for multiple women (Pagano et al., 2023; Dalton et al., 2022). These changes included functional improvements such as finding new interests and hobbies and having an increased feeling of independence (Dalton et al., 2022). For individuals with long-term illness who had exhausted conventional options, rTMS produced positive changes, mainly after treatment by altering underlying psychological processes (Dalton et al., 2022). For those recovering from coercive episodes, the shift involved consciously choosing to stop punishing themselves so much and becoming more caring towards themselves. This allowed the women to gain self-esteem and treating themselves with respect (Mac Donald et al., 2023). Receiving rTMS made participants feel more positive, open-minded, motivated, flexible, and willing to try new things both in their recovery from eating disorders and in other areas of their lives (Dalton et al., 2022). This

improved outlook on life underpinned functionalimprovements such as engaging in new interests and hobbies, as well as an increased sense of independence (Dalton et al., 2022). Specific self-management strategies included keeping a journal to help reduce the compulsive eating disorder thoughts and to work on examining and challenging them through fact-based reflection. Another cognitive strategy was to metaphorically imagine the brain as a radio and "turn down the volume" on the voice of the eating disorder. Listening to recovery podcasts and stories about inspiring women who had recovered were effective strategies for the women (Pagano et al., 2023). The process of letting go of compulsion was experienced as strongly linked to adopting new self-care habits, where participants consciously chose to stop punishing themselves and became more compassionate toward themselves (Mac Donald et al. 2023). Several patients in remission described stopping weighing was crucial for recovery because it made them realize that it doesn't matter what the scale says (Pagano et al., 2023).

Therapeutic sessions to focus on emotional exploration and insight into trauma or biology, rather than being solely focused on behavioral change was something many women described as a crucial element for future care (Pagano et al., 2023; Dalton et al., 2022; Zugai et al., 2024; Andersen et al., 2021; Chua et al., 2022; Cummings et al., 2023). Many women who have lived with or are living with Anorexia express the view that full recovery can be difficult to achieve, even with treatment, but that meaningful improvement and increased quality of life are still entirely possible (Andersen et al., 2021; Pagano et al., 2023; Mac Donald et al., 2023; Dalton et al., 2022; Cummings et al., 2023).

DISCUSSION

Discussion of methods

The methodological discussion in the study aims to reflect on the chosen methodological approaches, their strengths and limitations, and how these factors may have influenced the study's results. The study's methodology was inspired by Polit & Beck's sequence of tasks in a literature review. The study began with a definition of the purpose and research questions. The authors have also chosen to evaluate the methodological quality of the study and to ensure that the results are credible according to the criteria for qualitative research using Lincoln & Guba's framework, as described in (Polit & Beck, 2021, pp. 569–570). This framework is used to establish the trustworthiness or rigor of a qualitative study. The framework is based on five criteria that are central to assessing the study's quality: **credibility**, **dependability**, **confirmability**, **transferability**, and **authenticity**. Applying these criteria demonstrates that the authors take proactive responsibility for the rigor of the study and use verification strategies throughout the research process (Guba & Lincoln, 1994, cited in Polit & Beck, 2021, pp. 569–570). The authors have also chosen to address ethical aspects in the discussion of methods, as this study relies on sensitive experiences of a vulnerable group and includes descriptions of involuntary treatment.

The purpose of the study was to describe women's lived experiences of being in treatment for anorexia nervosa. The authors conducted a comprehensive literature study with a qualitative study design and systematically collected, evaluated, and synthesized existing research to answer their specific research questions (Polit & Beck, 2021, p. 82). The design was chosen to systematically gather, evaluate, and synthesize existing research, which allowed for a deeper exploration of women's lived experiences of being in treatment for anorexia nervosa. A strength of this is that the literature review provided a broad overview and a deeper understanding of the subject. A weakness was the time limitation, which may have affected the scope of the study by limiting the number of included result articles. Another weakness was that the choice of design excluded a broader, quantitative view of the participants' experiences, which would have been possible with a mixed-methods design.

To evaluate the quality of the included articles, the SBU review template for qualitative studies was used. The authors defined their own quality levels (low, moderate, high) to ensure that only articles of moderate or high quality were included. By strictly limiting inclusion to original articles that met SBU's criteria for moderate or high quality, the study's **credibility** was strengthened because we ensured that our synthesis was based on responsibly conducted research. To create structure and transparency in the study, a nine-step model inspired by Polit and Beck's flow of tasks in a literature review was followed (Polit & Beck, 2021, p. 85). A strength of this **approaability**, and thus the study's objectivity, both authors processed and reviewed the articles individually before we jointly discussed and agreed on the interpretations. This double-checking reduced the risk was that the structured process aimed to reduce the risk of bias, thereby enhancing the study's **credibility**. To ensure **confirm** of subjective misinterpretations.

The data collection was conducted through a systematic search in the databases CINAHL and PubMed. Both free text words and controlled search terms (MeSH terms and CINAHL Subject Headings) were used. The systematic nature of this data collection process was carried out to ensure **dependability** in the search process and **confirmability** in the selection. The strength of this choice of PubMed and CINAHL provided both medical and nursing perspectives. A weakness was that the authors are not accustomed to conducting systematic searches. This can lead to relevant articles being missed due to lack of knowledge in search techniques. A further limitation was that it is not explicitly stated in the

source whether the search term "experiences" existed as a searchable term in the controlled vocabularies, which could have resulted in relevant qualitative studies being overlooked.

The inclusion criteria limited the articles to women, qualitative original articles, the English language, and publication years 2020–2025. One strength was that the restriction to more recent research (2020–2025) enhanced the study's relevance. An additional strength that enhances the internal **credibility** was including only women in the study, as this choice reduced the variation that can occur between genders and contributed to a more homogeneous and comparable result. A limitation was including only English-language articles, which is a weakness since relevant research in other languages was excluded. The included studies demonstrated a geographical spread, with research conducted in the USA (4), England (3), Australia (3), and Denmark (2). While this provides a diverse perspective from Western healthcare systems, the lack of geographical spread to other cultural contexts may limit the **transferability** of the results. Regarding the quality of the material, only articles of moderate or high quality were included to strengthen the credibility of the synthesis. High-quality articles demonstrated a clear and consistent link between aim, methodology, and analysis. The five articles assessed as moderate quality presented minor methodological flaws, such as limited details regarding the researcher's background, but their findings were still deemed valuable and trustworthy for answering the study's aim. It is not explicitly reflected upon how the lack of geographical spread in the selection may limit the **transferability** of the results to other cultural contexts, which is an important quality criterion according to Lincoln and Guba (Guba & Lincoln, 1994, cited in Polit & Beck, 2021, p. 570).

The work with **authenticity** was central due to the sensitive nature of the study, which included stories of involuntary care and abuse of power. Handling the deeply sensitive nature of the collected data necessitated continuous ethical reflexivity, particularly regarding the representation of trauma and the patients lived experience. We took responsibility through continuous ethical reflexivity, with the aim of ensuring that the patient's voice was validated and not pathologized by a systematic focus on biomedical markers. This ethical approach ensured that the result synthesis genuinely reflected the lived experiences. The synthesis incorporated intense narratives detailing experiences of involuntary treatment, perceived abuse of power, and the subsequent long-term fear of hospitals (Mac Donald et al., 2023; Zugai et al., 2024). A key ethical challenge was ensuring the presentation of these experiences validated the patient's perspective, counteracting the risk of systemic disqualification or pathologizing their subjective voice inherent in a care system overly focused on biomedical markers (Holmes et al., 2021; Zugai et al., 2024). Furthermore, our methodological approach addressed ethical standards by strictly limiting inclusion to original articles that explicitly reported ethical approval and met predetermined moderate or high quality criteria following SBU (2022) critical appraisal. This systematic verification ensured the foundation of the discussion was built upon responsibly conducted research, thus supporting the ethical **credibility** of our findings and advocating respectfully for the patient's narrative within treatment contexts.

Discussion of results

The aim of this study was to describe women's lived experiences of being in treatment for AN, The synthesis of the results reveals that while AN is a severe and life-threatening psychological disorder, treatment interventions are often perceived as inadequate because they suffer from an overly narrow focus on weight gain. This discussion will interpret the identified themes (Deeper than the weight, Therapeutic relationships, and Continuity of Care by drawing on the core concepts of Person-centered care and the Care Relationship), and will discuss the clinical implications of the findings.

The singular focus on weight and biomedical markers (BMI) in eating disorder care represents a significant source of patient frustration and establishes systemic barriers to recovery. This clinical focus

has a dual negative effect: Firstly, patients experienced the focus on weight gain as too intense, often neglecting their deeper psychological and emotional struggles. Secondly, patients with Atypical Anorexia Nervosa were excluded from necessary specialist care due to weight stigma, where clinicians failed to recognize the severity of their condition because the BMI was not low enough to need treatment, thereby restricting access to vital care. In the study by Barko et al. (2023), participants (146 women, 1 who identified as a man, and 1 who selected other/not applicable) argued that AN is an extremely serious illness, but not one that is solely or even primarily about low weight. The strict weight boundary was shown to be a barrier to essential care, leading some patients to decline treatment entirely. In the study by Drinkwater et al. (2022) patricipants found true recovery to be defined as "freedom from the structure, from the rules, from the times". This involves moving away from the rigid preoccupation with weight and food to discover an authentic identity, the "real me", that exists independently of the disorder (Drinkwater et al.22). The authors contend that these results highlights how clinical recovery must extend beyond weight restoration, for sustainable change.

Patients experience of being treated solely based on their weight can also inadvertently reinforce anorectic cognitions, as they may feel a compulsion to physically convey the seriousness of their struggle. Even individuals living with Severe and Enduring Anorexia Nervosa expressed deep frustration with treatment approaches that only focused on eating and weight gain. Individuals felt they had to maintain a visibly emaciated appearance to have their illness taken seriously by medical professionals and the public (Barko et al., 2023). This suggest that the appearance of the disorder is what carries the most weight in the systematic assessment. Discharge planning was deemed inadequate because the intense focus on weight gain during hospitalization failed to sufficiently prepare patients psychologically for life outside of care. Patients were often discharged with the same maladaptive coping mechanisms they had before admission, leading to regression and cyclical readmissions. The results also show that the intensive focus on weight gain has a limited effect, as it does not prepare patients psychologically for life in the community.

This structural disqualification of the patient's story directly contradicts the fundamental principles of person-centered care (Holmström, 2022), which require healthcare to recognize the unique identity of the individual and empower them. The problem inherent in a weight-only focus directly contradicts the principles of Person-Centered Care (Holmström, 2022). When treatment exclusively focuses on the body's BMI and ignores the patient's subjective experiences and emotional core needs, the principle of caring for the person with the illness, rather than the illness in the person, is undermined. This is also highlighted in the ICN Code of Ethics (2021) which states that Person-Centered

Care is based on information about the person's lifestyle and values and aims to make care and the care environment more personal (ICN Code of Ethics, 2021). This highlights the importance of focusing on the whole person, with unique needs, resources and experiences, and not just on the disease. The interpretation of this theme is that an exclusive focus on the visual damage rather than the underlying psychological causes risks, invalidating the patient's identity and can be actively harmful. This raises questions about whether care succeeds in establishing the partnership relationship required within Person-Centered Care (Holmström, 2022), where treatment should be adapted according to the person's lifestyle and values. Furthermore, a positive Care Relationship relies on mutual trust to provide the security and strength needed to manage difficulties (Nyström, 2019).

The findings of this study underscore that a narrow clinical focus on weight and BMI often acts as a barrier to recovery, reinforcing anorectic mechanisms and causing patients to feel invalidated. The nurse's professional role includes meeting the patient in their experience of their situation. This involves gaining a deep understanding of the patient's underlying anxiety and desperate need for control, rather than viewing food refusal merely as clinical resistance (Brinchmann et al., 2024; Holyoake &

Jenkins, 1998). By establishing a care relationship based on mutual trust, the nurse can provide the security and strength needed to manage difficulties and reduce the sense of powerlessness that often arises from strict treatment boundaries (Nyström, 2019; Holyoake & Jenkins, 1998).

Furthermore, as the results identify that a lack of continuity during transitions significantly increases the risk of relapse, the nurse's role in structured prevention becomes vital. Because nurses maintain a close and intensive professional relationship with patients, they are in the most favorable position to lead structured relapse prevention work. Signs can include intensified anorectic thoughts, social withdrawal, or physical symptoms like cold hands and feet (Berends et al., 2012). Implementing these well-structured professional procedures provides a clear health benefit and is a fundamental component of person-centered care, ensuring that patients receive continuous support and are not abandoned during transitions (Holmström, 2022; Berends et al., 2012).

Beyond this singular focus on physical metrics, our findings underscore that the therapeutic relationship was crucial in mitigating the potentially harmful effects of necessary clinical use of power. While coercive measures were sometimes perceived as unavoidable in life threatening situations and in some cases even described as relief, their impact depended largely on the quality of the interpersonal relationship and the clinician's competence. Misuse of power, including unjustified restrictions on autonomy, was associated with reduced self-esteem, demotivation and long term fear of hospital care, ultimately creating barriers to help seeking and follow up treatment. This dynamic highlights the attitude's alignment with the concept of the care relationship (Nyström, 2019), which requires that the relationship must be personal yet professional, creating security and strength to deal with difficulties. Grogan et al. (2021) (This study included two men in the client group (13%) and five men in the clinician group (33%) Describes, In summary, the therapeutic relationship functions as a collaborative bridge. It provides the safety and validation necessary for the patient to stop using the eating disorder as a shield, while simultaneously pushing the patient toward the autonomy required to live a life that is no longer defined by the illness (Grogan et al. 2021).

Voswinkel et al. (2021) describes that recovery is supported when the care relationship recognizes the patient as a whole person and an active co-creator in their care. This article included participants that were sixteen or older (Voswinkel et al., 2021). At the same time, coercion, distrust, and unreflective externalization of the illness can undermine autonomy, hinder recovery, and increase the risk of relapse. These findings underscore the central principle of person-centered care , which requires acknowledging the patient's identity and valuing their lived experience in order to foster security, dignity and hope (Holmström, 2022).

To address persistent vulnerabilities after intensive treatment, the results highlight a clear need for improved continuity, planning, and transitional care. The transition from inpatient to outpatient services was frequently described as fragmented, leaving patients discharged with unchanged maladaptive coping strategies and contributing to relapse and repeated readmissions. Telehealth emerged as a positively perceived step-down intervention, offering integrated support between levels of care and representing a promising way forward to enhance continuity after discharge. This lack of continuity stands in direct contradiction to the principles of person-centered care, which emphasize sustained support across care transitions to prevent abandonment (Holmström, 2022). At the same time, Bell et al. (2024) present that self-disgust is a deeply rooted and persistent feeling that often remains in individuals with AN even after they are considered physically recovered. The authors believe that this strengthens the result, as it suggests that the treatment often fails to address the underlying factor, which in turn leads to incomplete recovery (Bell et al. 2024).

The results show a profound internal struggle to separate the self from the eating disorder identity and to envision a meaningful future beyond illness. Anorexia Nervosa was often experienced as an integrated and natural part of the self, which complicated motivation for recovery and made it difficult to imagine life without the disorder. A consistent turning point emerged when patients discovered a meaningful commitment or passion outside the illness, fostering hope and a renewed sense of purpose. Voswinkel et al. (2021) highlights that patients experiences of anorexia nervosa vary along a spectrum, from being perceived as an integrated part of identity to being experienced as a foreign and imposed force (Voswinkel et al. 2021). These different identity positions have important clinical implications, as effective treatment needs to support both cognitive flexibility and identity development, rather than solely focusing on external levels of functioning (Keeler et al. 2022). The authors contend that the articles strengthen the results by highlighting how the women in the study experience a constant internal struggle between their own identity and the foreign anorexia voice, confirming that successful treatment must prioritize psychological separation and cognitive flexibility over an exclusive focus on physical metrics such as weight and BMI.

Hope thus appears as a central component of the care relationship, providing motivation and direction during recovery (Nyström, 2019). In line with Person-Centered Care, empowerment and dignity were further strengthened when patients were granted agency in treatment decisions, such as choosing therapeutic components aligned with their needs and values (Holmström, 2022).

The study reveals that recovery was experienced as a profound shift in internal self-perception and future outlook, affirming an identity distinct from AN. Psychological therapy was viewed as essential when it focused on emotional exploration and insight into underlying struggles, rather than being limited to behavioral change. This provided a safe space for self-discovery, which was crucial for patients to move from being a defective diagnosis to a valued partner in their own healing. Furthermore, letting others in such as family, friends, and peer support was vital for creating solidarity and regaining a sense of purpose separate from the illness. This process allowed for the emergence of a new self, where reclaiming personal agency and finding a passion outside of AN served as critical turning points in the recovery process. However, Bell et al. (2024) state that this process is complicated by the fact that self-loathing is a deeply rooted and persistent feeling that is often reinforced by the physical signs of recovery, such as weight gain, making the feeling a significant barrier and a powerful driver of relapse (Bell et al., 2024).

The authors contend that focusing solely on weight and BMI, without building a strong care relationship or ensuring continuity, is like trying to navigate a ship in a storm by only looking at the fuel gauge. You might see that there is energy in the engine (physical weight), but you miss that both the captain (the patient's identity, which has been lost to the disorder) and the steering mechanism (the therapeutic relationship, which is more critical for engagement than the method itself) are broken. Without addressing these underlying psychological needs and providing a structured transition back to the community, the ship will inevitably drift back toward the rocks of relapse and cyclical readmission.

CONCLUSION

The results demonstrate that AN treatment is fundamentally compromised by an over-reliance on physical metrics like BMI, which reinforces anorectic mechanisms and overlooks the patient's underlying psychological needs. A central finding representing the results as a whole is that the quality of the therapeutic relationship, characterized by trust and the validation of the patient's voice is more critical for engagement and recovery than the specific treatment method employed. Furthermore, the findings highlight that a lack of continuity during transitions from inpatient care creates structural failures that significantly increase the risk of relapse and cyclical readmissions. Clinical implications suggest that nursing care must transition toward a person-centered model that prioritizes identity development and psychological separation from the "anorexia voice". Specifically, clinicians should implement interventions such as the "Voice Dialogue" method to help patients externalize the illness and utilize telehealth as a structured "step-down" protocol to bridge the gap between intensive treatment and community reintegration. Suggestions for future research should include evaluating the effectiveness of specific nursing-led interventions that facilitate identity reclamation and cognitive flexibility. There is also a need for longitudinal studies comparing different transitional care protocols to determine which strategies most effectively reduce readmission rates. Finally, future research should incorporate more diverse demographics and cultural contexts to enhance the transferability of these recovery strategies.

REFERENCES

To clarify, articles included in the results are marked with a *

* Andersen, S. T., Linkhorst, T., Gildberg, F. A., & Sjögren, M. (2021). Why do women with eating disorders decline treatment? A qualitative study of barriers to specialized eating disorder treatment. *Nutrients, 13*(11), 4033. https://doi.org/10.3390/nu13114033

Barko, E. B., & Moorman, S. M. (2023). Weighing in: qualitative explorations of weight restoration as recovery in anorexia nervosa. Journal of Eating Disorders, 11(1), 14. https://doi.org/10.1186/s40337-023-00736-9

Berends, T., van Meijel, B., & van Elburg, A. (2012). The Anorexia Relapse Prevention Guidelines in Practice: A Case Report. *Perspectives in Psychiatric Care*, 48(3), 149–155. https://doi.org/10.1111/j.1744-6163.2011.00322.x

Bell, K., Coulthard, H., Wildbur, D., & Williamson, I. (2024). How enduring and multi-faceted self-disgust threatens psychological recovery from anorexia nervosa: A qualitative enquiry. *The Mental Health Review*, 29(3), 301-317. https://doi.org/10.1108/MHRJ-06-2022-0039

Berg, L. & Lepp, M. (2022). Den vårdande relationen. In L. Wiklund Gustin & M. Asp (Eds.), *Vårdvetenskapliga begrepp i teori och praktik* (3rd ed., p. 483). Studentlitteratur.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V. & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis. *Qualitative Research in Psychology, 18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Brinchmann, B. S., Moyo, K. R., & Stavnes, K. A. (2024). "Holding the line"-relationship building and challenges when nursing adults with a severe eating disorder. *Journal of eating disorders*, *12*(1), 198. https://doi.org/10.1186/s40337-024-01155-0

Centre for Eating Disorders Innovation (2025). *Vad händer i kroppen?* Retrieved March 5, 2025 from https://atstorning.se/vad-hander-i-kroppen/

Chen, L., Lu, Y., Zhou, Y.-F., Wang, Y., Zhan, H.-F., Zhao, Y.-T., Wang, Y.-L., Zhang, F.-F., Chen, H., & Li, X. (2023). The effects of weight loss-related amenorrhea on women's health and the therapeutic approaches: a narrative review. Annals of Translational Medicine, 11(2), 132. https://doi.org/10.21037/atm-22-6366

* Chua, N., Serpell, L., Burnett-Stuart, S. & Pugh, M. (2022). Interviewing anorexia: How do individuals given a diagnosis of anorexia nervosa experience voice dialogue with their eating disorder voice? A qualitative analysis. Clinical Psychology & Psychotherapy, 29(2), 600–610. https://doi.org/10.1002/cpp.2652

* Cummings, M. P., Alexander, R. K., & Boswell, R. G. (2023). Ordinary days would be extraordinary: The lived experiences of severe and enduring anorexia nervosa. *International Journal of Eating Disorders, 56*(12), 2273–2282. https://doi.org/10.1002/eat.24058

* Dalton, B., Austin, A., Ching, B. C. F., Potterton, R., McClelland, J., Bartholdy, S., Kekic, M., Campbell, I. C., & Schmidt, U. (2022). "My dad was like "it's your brain, what are you doing?" Participant experiences of repetitive transcranial magnetic stimulation treatment in severe enduring anorexia nervosa. *European Eating Disorders Review, 30*(3), 237–249. https://doi.org/10.1002/erv.2890

Davén, J., Hellzen, O., & Häggström, M. (2022). Encountering patients with anorexia nervosa - An emotional roller coaster. nurses' lived experiences of encounters in psychiatric inpatient care. International journal of qualitative studies on health and well-being, 17(1), 2069651. https://doi.org/10.1080/17482631.2022.2069651

Drinkwater, D., Holttum, S., Lavender, T., Startup, H., & Oldershaw, A. (2022). Seeing through the façade of anorexia: A grounded theory of emotional change processes associated with recovery from anorexia nervosa. Frontiers in Psychiatry, 13, 868586. https://doi.org/10.3389/fpsyt.2022.868586

Foà, C., Bertuol, M., Deiana, L., Rossi, S., Sarli, L., & Artioli, G. (2019). The case/care manager in eating disorders: The nurse's role and responsibilities. *Acta Biomedica, 90*, 17–28. https://doi.org/10.23750/abm.v90i11-S.8989

Forsberg, C. & Wengström, Y. (2016). Att göra systematiska litteraturstudier: Värderingar, analys och presentation av omvårdnadsforskning. Fjärde utgåvan. Natur och Kultur.

Grogan, K., O'Daly, H., Bramham, J., Scriven, M., Maher, C., & Fitzgerald, A. (2021). A qualitative study on the multi-level process of resilience development for adults recovering from eating disorders. Journal of Eating Disorders, 9(1), 71. https://doi.org/10.1186/s40337-021-00422-8

* Harrop, E. N., Hutcheson, R., Harner, V., Mensinger, J. L., & Lindhorst, T. (2024). "You don't look anorexic": Atypical anorexia patient experiences of weight stigma in medical care. *International Journal of Eating Disorders*. https://doi.org/10.1016/j.bodyim.2023.04.008

* Holmes, S., Malson, H., & Semlyen, J. (2021). Regulating "untrustworthy patients": Constructions of "trust" and "distrust" in accounts of inpatient treatment for anorexia. *Feminism & Psychology, 31*(1), 41–61. https://doi.org/10.1177/0959353520967516

Holmström, I. (2022). Personcentrerad vård. In L. Wiklund Gustin & M. Asp (Eds.), *Vårdvetenskapliga begrepp i teori och praktik* (3rd ed., p. 435). Studentlitteratur.

Holyoake D, & Jenkins M. (1998). Mental health nursing. PAT: advanced nursing interventions for eating disorders. *British Journal of Nursing, 7*(10), 596–600. https://doi-org.till.biblextern.sh.se/10.12968/bjon.1998.7.10.5685

Hovde, K., Markovchick, T., Netzky, J., Sandberg, H., & Mehler, P. S. (2021). Care of the Hospitalized Patient with Severe Anorexia Nervosa or Avoidant Restrictive Food Intake Disorder. *MEDSURG Nursing, 30*(3), 197–211. https://doi-org.till.biblextern.sh.se/10.62116/msj.2021.30.3.197

Keeler, J. L., Konyn, C. Y., Treasure, J., Cardi, V., Himmerich, H., Tchanturia, K., & Mycroft, H. (2022). "Your mind doesn't have room for anything else": A qualitative study of perceptions of cognitive

functioning during and after recovery from anorexia nervosa. Journal of Eating Disorders, 10(201). https://doi.org/10.1186/s40337-022-00723-6

Mac Donald, B., Bulik, C. M., Larsen, J. T., Carlsen, A. H., Clausen, L., & Petersen, L. V. (2023). Involuntary treatment in patients with anorexia nervosa: Utilization patterns and associated factors. *Psychological medicine, 53*(5), 1999–2007. https://doi.org/10.1017/S003329172100372X

* Mac Donald, B., Gustafsson, S. A., Bulik, C. M., & Clausen, L. (2023). Living and leaving a life of coercion: A qualitative interview study of patients with anorexia nervosa and multiple involuntary treatment events. *Journal of Eating Disorders, 11*, 40. https://doi.org/10.1186/s40337-023-00765-4

McClelland, J., Kekic, M., Bozhilova, N., Nestler, S., Dew, T., Van den Eynde, F., David, A. S., Rubia, K., Campbell, I. C., & Schmidt, U. (2016). A randomised controlled trial of neuronavigated repetitive transcranial magnetic stimulation (rTMS) in anorexia nervosa. *PloS one, 11*(3), e0148606. https://doi.org/10.1371/journal.pone.0148606

National assosiation of Anorexia Nervosa and associated disorders (2024). *Eating disorder statistic.* Retrieved March 4, 2024 from https://anad.org/eating-disorder-statistic/#general

National eating disorder association (2025). *Research.* Retrieved March 4, 2025 from https://www.nationaleatingdisorders.org/research/

Nyström, M. (2019). Vårdrelationer. In F. Friberg & J. Öhlén (Eds.), *Omvårdnadens grunder: Perspektiv och förhållningssätt* (3rd ed., pp. 468–474). Studentlitteratur.

O'Connor, P., Donohue, G., Morrissey, J., Needham, M., Hargadon, L., & O'Toole, C. (2023). An exploration of patient experiences of transitioning to a remote day programme following inpatient treatment in an adult eating disorder service. *Journal of Psychiatric and Mental Health Nursing.* https://doi.org/10.1111/jpm.12949

* Pagano, N., Glasofer, D. R., Attia, E., Ruggiero, J., Eziri, K., Goldstein, C. M., & Steinglass, J. E. (2023). Perspectives on relapse prevention following intensive treatment of anorexia nervosa: A focus group study. *International Journal of Eating Disorders, 56*(7), 1417–1431. https://doi.org/10.1002/eat.23952

Polit, D. F. & Beck, C. T. (2021). *Nursing research: Generating and assessing evidence for nursing practice* (11th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.

Quadflieg, N., Naab, S., Schlegl, S., Bauman, T., & Voderholzer, U. (2023). Inpatient treatment outcome in a large sample of adolescents with anorexia nervosa. *Nutrients, 15*(19), 4247. https://doi.org/10.3390/nu15194247

* Rankin, R., Conti, J., Ramjan, L., & Hay, P. (2025). It takes a village: Patient lived experiences of residential treatment for an eating disorder. *BJPsych Open, 11*(2), e30. https://doi.org/10.1192/bjo.2024.849,

Socialstyrelsen (2024). *Nationella riktlinjer 2024: Ätstörningar.* https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/nationella-riktlinjer/2024-5-9039.pdf

Stallman, H. M. & Gupta, V. (2025, 20 januari). Involuntary commitment. I StatPearls [Internet]. Retrieved 5 december 2025 from https://www.ncbi.nlm.nih.gov/books/NBK557377/.

Tosi, C., Patanè, D., Natali, L., Meregalli, V., & Cardi, V. (2025). Meanings of recovery and post-traumatic growth in people with lived experience of eating disorders: a qualitative study. Journal of Eating Disorders, 13(70). https://doi.org/10.1186/s40337-025-01258-2

Van Eeden, A. E., van Hoeken, D., & Hoek, H. W. (2021). Incidence, prevalence and mortality of anorexia nervosa and bulimia nervosa. *Current Opinion in Psychiatry, 34*(6), 515–524. https://doi.org/10.1097/YCO.0000000000000739

Vetenskapsrådet (2017). *God forskningsed.* https://www.vr.se/download/18.2412c5311624176023d25b05/1555332112063/God-forskningssed_VR_2017.pdf

Voswinkel, M. M., Rijkers, C., van Delden, J. J. M., & van Elburg, A. A. (2021). Externalizing your eating disorder: a qualitative interview study. Journal of Eating Disorders, 9(1), 128. https://doi.org/10.1186/s40337-021-00486-6

Watson, H. J., Yilmaz, Z., & Thornton, L. M. (2019). Genome-wide association study identifies eight risk loci and implicates metabo-psychiatric origins for anorexia nervosa. *Nature Genetics, 51*, 1207–1214. https://doi.org/10.1038/s41588-019-0439-2

* Zugai, J. S., Gill, K. & Ramjan, L. (2024). Clinicians' power in the inpatient care of anorexia nervosa: A qualitative investigation of consumer perspectives. International Journal of Mental Health Nursing, 33, 885–893. https://doi.org/10.1111/inm.13287

* Zugai, J. S., Gill, K., Molloy, L., Raeburn, T., & Ramjan, L. (2023). The focus on weight in the inpatient care of anorexia nervosa: A qualitative investigation of consumer perspectives. *International Journal of Mental Health Nursing,* 33, 388–396. https://doi.org/10.1111/inm.13242

APPENDIX I. SBU template assessment of studies with qualitative methodology.

Bedömning av studier med kvalitativ metodik

UPPDATERAD 2022-05-11

Författare: _____ År: _____

Granskare: _____

Sammanvägd bedömning av metodologiska brister:
Obetydliga eller mindre ❑ Måttliga ❑
Stora brister, studien ingår inte i syntesen ❑
Kommentarer:

1. Överensstämmelse mellan filosofisk hållning/teori och urval och metodik i studien[1]

Vilken teori eller filosofisk hållning utgick författarna från?

Hänger syfte och fråga ihop med teori/filosofisk hållning?	Ja	Nej	Oklart
	❑	❑	❑

Kommentarer:

2. Deltagare

Hur gjordes urvalet?

Stödfrågor för bedömning av brister i urvalsförfarandet:	Ja	Nej	Oklart
Är urvalet lämpligt för att besvara frågan?	❑	❑	❑
Är rekryteringsmetoden lämpligt vald och genomförd?	❑	❑	❑
Finns det allvarliga brister som kan påverka tillförlitligheten?	❑	❑	❑

Kommentarer:

3. Datainsamling

Vilka metoder användes för datainsamling?

Finns det allvarliga brister i datainsamlingen som kan påverka tillförlitligheten?	Ja	Nej	Oklart
	❑	❑	❑

Kommentarer:

4. Analys

Vilka metoder användes för analys?

Stödfrågor för bedömning av brister i analyssteget:	**Ja**	**Nej**	**Oklart**
Är vald analysmetod lämplig och genomförd på ett lämpligt sätt?	❑	❑	❑
Var forskarna reflexiva vid tolkning av data?	❑	❑	❑
Validerades tolkningarna?	❑	❑	❑
Finns det allvarliga brister i analysen som kan påverka tillförlitligheten?	❑	❑	❑

Kommentarer:

5. Forskaren

Vilken bakgrund och kompetens hade forskarna?

Stödfrågor för bedömning av brister:	**Ja**	**Nej**	**Oklart**
Har forskarna någon relation till studiedeltagarna som kan påverka datainsamlingen?	❑	❑	❑
Har forskarna hanterat sin förförståelse på ett acceptabelt sätt?	❑	❑	❑
Var forskarna oberoende av finansiella eller andra förutsättningar som kunde påverka analysen?	❑	❑	❑
Finns det allvarliga brister som kan påverka tillförlitligheten?	❑	❑	❑

Kommentarer:

Gör en total bedömning av risken för att metodproblem påverkar resultaten. För in det på sidan 1.

APPENDIX II. Article matrix

Author, year, journal, country	Title	Method (Design, sample, data collection, analysis)	Results	Quality
#1 Sofie T Andersen, Thea Linkhorst, Frederik A Gildberg, Magnus Sjögren, (2021), Nutrients. Denmark	Why Do Women with Eating Disorders Decline Treatment? A Qualitative Study of Barriers to Specialized Eating Disorder Treatment.	**Design:** Qualitative design **Sample:** consisted of 18 women (who had been referred to a specialized eating disorder unit, attended initial assessments, but then declined to initiate treatment). Ages: 20-46 years. **Data collection:** Individual, in-depth, semi-structured interviews conducted face-to-face and audio-recorded. **Analysis:** The collected data was analyzed using thematic analysis.	Patients avoided specialized treatment due to rigid weight-focused procedures, lack of autonomy, and deep distrust. They felt excluded if "not underweight enough," creating fundamental barriers to engagement.	High
#2 Emma Elizabeth Curry and Panoraia Andriopoulou, (2023). *Mental Health Review Journal*, Vol. 28, No. 4, pp. 396-413. United Kingdom	"Dual-experiences" of treatment for anorexia nervosa: an interpretative phenomenological analysis of experiences of treatment by service providers who are recovered service users	**Design:** Phenomenological approach **Sample:** 4 UK female participants (recovered AN service users working as providers). Ages: Adults (Specific age range not provided in detail) **Data Collection:** Individual semi- structured interviews. **Analysis:** Interpretative Phenomenological Analysis	The therapeutic relationship quality was more critical for patient engagement than the specific treatment method used. Narrow weight focus was universally detrimental, reinforcing anorectic thoughts. Staff with dual experience provided valuable hope and normalization	Moderate
#3 Rebekah Rankin, Janet Conti, Lucie Ramjan, Phillipa	'It takes a village': patient lived experiences of	**Design:** Qualitative **Sample:** 15 women, medianage: 27,9. **Data collection:** Semi-structured	Patients stressed the importance of relationships, collaboration, and reclaiming identity beyond the ED. The residential setting provided solidarity via	High

Hay, P. BJ Psych Open. (2025). Australia.	residential treatment for an eating disorder	interviews. **Analysis:** inductive reflexive thematic analysis within a social constructionist framework	peer support. Abrupt care transitions and financial barriers were key factors causing setbacks	
#4 Mac Donald, B., Gustafsson, S. A., Bulik, C. M., & Clausen, L. (2023). *Journal of Eating Disorders*, *11*(40). Denmark.	Living and leaving a life of coercion: a qualitative interview study of patients with anorexia nervosa and multiple involuntary treatment events.	**Design:** Qualitative **Sample:** 7 Female participants, Aged 18-30 years. **Data collection:** Semi-structured interviews. Initial + follow up. **Analysis:** Reflexive thematic analysis. The researchers adopted an inductive approach.	Patients experienced intense internal compulsion from AN before facing external coercion. Involuntary treatment (IT) felt negative due to lost control, but forced feeding sometimes brought relief from nutritional burden. IT often created trauma and deterred future care-seeking behaviors	High
#5 Joel Sebastian Zugai, Katherine Gill, Luke Molloy, Toby Raeburn, and Lucie Ramjan 2023). I*nternational Journal of Mental Health Nursing (*Australia)	The focus on weight in the inpatient care of anorexia nervosa: A qualitative investigation of consumer perspectives	**Design**: Qualitative descriptivedesign. **Sample:** 10 women (aged >18) .(who previously been hospitalised specifically for AN. **Data collection:** in-depth semi- structured interviews. **Analysis:** Thematic analysis using inductive analysis approach.	Inpatient care's hyper-focus on weight neglected psychological needs and led to harmful staff dynamics. This focus led to inadequate discharge preparation and the repetition of coping mechanisms. This resulted in cyclical readmissions	Moderate
#6 Natalie Chua, Lucy Serpell, Sarah Burnett-Stuart, Matthew Pugh, 2022, *Clinical Psychology & Psychotherapy,* UK (United Kingdom)	Interviewing anorexia: How do individuals given a diagnosis of anorexia nervosa experience Voice Dialogue with their eating	**Design**: Qualitative **Sample:** 9 individuals with AN and self-reported EDV. Ages: 20-31 years. **Data collection:** Voice Dialogue session followed by a post- intervention interview.	Voice Dialogue used physical separation (chairs) to help participants relate to the EDV as a distinct entity. This boosted metacognitive awareness and reduced the EDV's perceived power.	Moderate

	disorder voice? A qualitative analysis	**Analysis**: Interpretative Phenomenological Analysis	Understanding the voice's protective function increased the motivation to challenge the illness	
#7 Bethan Dalton, Amelia Austin, Brian C. F. Ching, Rachel Potterton, Jessica McClelland, Savani Bartholdy, Maria Kekic, Iain C. Campbell, Ulrike Schmidt, 2022, *European Eating Disorders Review,* UK (United Kingdom)	'My dad was like "it's your brain, what are you doing?"': Participant experiences of repetitive transcranial magnetic stimulation treatment in severe enduring anorexia nervosa	**Design:** Qualitative embedded in RCT feasibility study. **Sample:** 9 participants (of 29 total) with Severe Enduring AN (SE-AN). Mean Age: 30.10 **Data Collection:** Semi-structured interviews **Analysis:** Inductive content analysis	rTMS was considered an acceptable but time-consuming treatment. Many who received real rTMS described positive changes in their quality of life, such as becoming more positive, open-minded, flexible, and willing to try new things. Participants expressed initial concerns about the brain-targeted nature of rTMS, including worries about discomfort and losing control or autonomy.	High
#8 Joel Sebastian Zugai, Katherine Gill, Lucie Ramjan 2024, *International Journal of Mental Health Nursing,* Australia	Clinicians' power in the inpatient care of anorexia nervosa: A qualitative investigation of consumer perspectives	**Design:** Qualitative Descriptive Design. **Sample:** 10 adult women with AN in the community (previously inpatient). (Specific age range not provided in detail) **Data Collection:** Semi-structured interviews conducted online. **Analysis:** Thematic analysis	Abuses of power and excessive coercion were common and often perceived as punishment. However, life-saving measures were retrospectively appreciated as necessary interventions. The validity of clinical power relied on clinical competence and strong interpersonal relationship	Moderate
#9 Nikki Pagano, Deborah R. Glasofer, Evelyn Attia, Julia ruggiero, Kelechi Eziri, Carly M. Goldstein, Joanna E. Steinglass, 2023, *International Journal of Eating disorders,* USA (United States)	Perspectives on relapse prevention following intensive treatment of Anorexia Nervosa: A focus group study	**Design:** Qualitative focus group study. **Sample:** 7 adult women (remission from AN) previously received inpatient treatment. Ages 23-51years. **Data collection:** Two semi-structured focus groups (70-90 min) via zoom. **Analysis:** Rapid qualitative analysis procedure.	Key recovery aids included finding a passion and gaining personal agency in treatment decisions. Continuity of care and telehealth as a "step-down" option were highly valued. Opinions varied on whether routine weighing was beneficial or reinforced that the number mattered.	High

#10 Erin N. Harrop, Rebecka Hutcheson, Vern Harner, Janell L. Mensinger, Taryn Lindhors, 2024, *International Journal of Eating Disorders*. USA	"You don't look anorexic": Atypical Anorexia Patient Experiences of Weight Stigma in Medical care.	**Design:** Qualitative Study. **Sample:** 39 Adult patients with Atypical Anorexia Nervosa (AAN). Ages 18-74. **Data Collection:** In-depth semi-structured interviews (6-month interview analyzed). **Analysis:** Thematic Analysis	Participants reported that weight stigma throughout the healthcare system initiated and maintained eating disorder behaviors and contributed to delayed care. Providers pathologized the patient's weight and failed to recognize the eating disorder because the patients were not underweight; in some cases, they even congratulated weight loss. This stigma led to suboptimal treatment environments and decreased patients' willingness to seek necessary medical care.	High
#11 Melinda Parisi Cummings, Robbi K. Alexander, A, Rebecca G. Boswell. (2023), International journal of eating disorders. USA	"Ordinary days would be extraordinary": The lived experiences of severe and enduring anorexia nervosa	**Design:** Qualitative study **Sample:**17 participants with severe enduring AN. Mean age 45 years. **Data collection:** Semi-structured interviews **Analysis:** Inductive reflexive thematic analysis.	Overall, individuals noted clear insight about their condition, both negative and positive experiences with previous treatment, and hope for better quality of life despite their illness. Positive treatment experiences relied on provider compassion and collaborative alignment, while negative experiences involved harmful misalignment and rigidity.	High
#12 Holmes, Su; Malson, Helen; Semlyen, Joanna, 2021, *Feminism & Psychology,* United States of America USA California.	Regulating 'untrustworthy patients': Constructions of 'trust' and 'distrust' in accounts of inpatient treatment for anorexia	**Design: Qualitative study Sample: 14 women with inpatient AN experience, aged 20 to 42 years. Data Collection: Semi-structured interviews (approx. 1 hour). Analysis: Thematic analysis within a Post structural, discourse-analytic framework**	The analysis showed that there was a perceived lack of trust towards the patients in the inpatient care, which was manifested by a disqualification of their "voice". This led to serious negative consequences for the participants, such as erosion of self- esteem, demotivation and triggering of experiences of trauma. The results question routine treatment methods and the serious consequences of constructing anorexia patients as manipulative and untrustworthy.	Moderate

APPENDIX III: Search Matrix in CINAHL

Database, date, search	keywords	Limitations	Number of hits	Number of read titles	Number of read abstracts	Number of read artiicles	Number of chosen articles	Article #
CINAHL 251911	((anorexia nervosa OR anorexia)) AND ((treatment OR therapy OR care OR recovery))	None	7,701	0	0	0	0	0
CINAHL 251911	(patient OR women OR consumer) AND (experience OR lived experience OR perspective OR view)	None	355,945	0	0	0	0	0
CINAHL 251911	(qualitative OR interview OR study)		3,472,969	0	0	0	0	0
CINAHL 251911(+exklusionscriteria)	S1 S2 S3	<5 year Peer reviewed	168	168	57*	25**	6***	#2 #7 #8 #9 #10 #12

*111 articles excluded as their titles did not clearly describe their relevance to the aim of the study.

**32 articles excluded because they were not from patient perspective.

***After complete examination of articles 19 were excluded because their aim was more aimed for other types of eating disorders than anorexia nervosa.

APPENDIX IV: Search Matrix in Pubmed

Database, date, search	keywords	Limitations	Number of hits	Number of read titles	Number of read abstracts	Number of read artiicles	Number of chosen articles	Article #
Pubmed 251121	Anorexia nervosa AND treatment or therapy or recovery	none	3, 049	0	0	0	0	
Pubmed 251121	Patient or women AND Experience or lived experience perspective or view AND Qualitative or interview	none	95,986	0	0	0	0	
PubMed 251121 (+exklusionscriteria)	S1 AND S2 AND S3		145	145	*80	**30	***6	#1 #3 #4 #5 #6 #11

*100 articles excluded for not answering to the aim for this study. Or duplicates from CINAHL.

** 30 articles excluded for not being qualitative research.

*** After complete examination of articles, 24 were excluded because their aim was more aimed for other types of eating disorders than anorexia nervosa.

Swedish Red Cross University
P.O. Box 1059 | SE-141 21 Huddinge, Sweden
Visiting adress: Hälsovägen 11
Telephone: +46-8 587 516 00 | www.rkh.se